Senate Bill No. 870

Passed the Senate September 7, 1999

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Secretary of the Senate

Passed the Assembly September 2, 1999

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Chief Clerk of the Assembly

This bill was received by the Governor this _____ day

of _____, 1999, at _____ o'clock ____M.

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Private Secretary of the Governor

CHAPTER _____

An act to amend Sections 10232.1, 10232.2, 10232.3, 10232.4, 10233.2, 10233.5, 10235.2, 10235.8, 10235.30, 10235.40, 10235.50, 10235.52, 10237.1, 10237.4, and 10237.5 of, to add Sections 10232.97 and 10235.94 to, and to repeal and add Section 10232.92 of, the Insurance Code, relating to long-term care insurance.

LEGISLATIVE COUNSEL'S DIGEST

SB 870, Vasconcellos. Long-term care insurance.

Existing law prescribes various requirements and conditions governing the delivery or issuance for delivery in this state of individual or group long-term care insurance.

This bill would make various changes to those provisions, including changes clarifying an insurer's obligations to file, offer, and market policies intended to be federally qualified and policies that are not intended to be federally qualified; changes mandating coverage for care in a residential care facility; changes relating to coverage for preexisting conditions; changes regarding prohibited policy provisions and prohibited insurer actions in connection with policies; and changes regarding the right of a policy or certificate holder to appeal decisions regarding benefit eligibility, care plans, services and providers, and reimbursements.

The people of the State of California do enact as follows:

SECTION 1. Section 10232.1 of the Insurance Code is amended to read:

10232.1. (a) Every policy that is intended to be a qualified long-term care insurance contract as provided by Public Law 104-191 shall be identified as such by prominently displaying and printing on page one of the policy form and the outline of coverage and in the application the following words: ''This contract for long-term care insurance is intended to be a federally

qualified long-term care insurance contract and may qualify you for federal and state tax benefits.'' Every policy that is not intended to be a qualified long-term care insurance contract as provided by Public Law 104-191 shall be identified as such by prominently displaying and printing on page one of the policy form and the outline of coverage and in the application the following words: ''This contract for long-term care insurance is not intended to be a federally qualified long-term care insurance contract.''

(b) Any policy or certificate in which benefits are limited to the provision of institutional care shall be called a ''nursing facility and residential care facility only'' policy or certificate and the words ''Nursing Facility and Residential Care Facility Only'' shall be prominently displayed on page one of the form and the outline of coverage. The commissioner may approve alternative wording if it is more descriptive of the benefits.

(c) Any policy or certificate in which benefits are limited to the provision of home care services, including community-based services, shall be called a ''home care only'' policy or certificate and the words ''Home Care Only'' shall be prominently displayed on page one of the form and the outline of coverage. The commissioner may approve alternative wording if it is more descriptive of the benefits.

(d) Only those policies or certificates providing benefits for both institutional care and home care may be called ''comprehensive long-term care'' insurance.

SEC. 2. Section 10232.2 of the Insurance Code is amended to read:

10232.2. (a) Every insurer that offers policies or certificates that are intended to be federally qualified long-term care insurance contracts, including riders to life insurance policies providing long-term care coverage, shall fairly and affirmatively concurrently file, offer, and market long-term care insurance policies or certificates not intended to be federally qualified, as described in subdivision (a) of Section 10232.1.

(b) All long-term care insurance contracts, including riders to life insurance contracts providing long-term care coverage, approved after the effective date of this section shall meet all of the requirements of this chapter.

(c) Until July 1, 2001, or 90 days after approval of contracts submitted for approval pursuant to subdivision (b), whichever comes first, insurers may continue to offer and market previously approved long-term care insurance contracts.

(d) Group policies issued prior to January 1, 1997, shall be allowed to remain in force and not be required to meet the requirements of this chapter, as amended during the 1997 portion of the 1997–98 Regular Session, unless those policies cease to be treated as federally qualified long-term care insurance contracts. If a policy or certificate issued on a group policy of that type ceases to be a federally qualified long-term care insurance contract under the grandfather rules issued by the United States Department of the Treasury pursuant to Section 7702B(f)(2) of the Internal Revenue Code, the insurer shall offer the policy and certificate holders the option to convert, on a guaranteed-issue basis, to a policy or certificate that is federally tax qualified if the insurer sells tax-qualified policies.

SEC. 3. Section 10232.3 of the Insurance Code is amended to read:

10232.3. (a) All applications for long-term care insurance except that which is guaranteed issue, shall contain clear, unambiguous, short, simple questions designed to ascertain the health condition of the applicant. Each question shall contain only one health status inquiry and shall require only a ‘‘yes’’ or ‘‘no’’ answer, except that the application may include a request for the name of any prescribed medication and the name of a prescribing physician. If the application requests the name of any prescribed medications or prescribing physicians, then any mistake or omission shall not be used as a basis for the denial of a claim or the recision of a policy or certificate.

(b) The following warning shall be printed conspicuously and in close conjunction with the applicant's signature block:

''Caution: If your answers on this application are misstated or untrue, the insurer may have the right to deny benefits or rescind your coverage.''

(c) Every application for long-term care insurance shall include a checklist that enumerates each of the specific documents which this chapter requires be given to the applicant at the time of solicitation. The documents and notices to be listed in the checklist include, but are not limited to, the following:

(1) The ''Important Notice Regarding Policies Available'' pursuant to Section 10232.25.

(2) The outline of coverage pursuant to Section 10233.5.

(3) The HICAP notice pursuant to paragraph (8) of subdivision (a) of Section 10234.93.

(4) The long-term care insurance shoppers guide pursuant to paragraph (9) of subdivision (a) of Section 10234.93.

(5) The ''Long-Term Care Insurance Personal Worksheet'' pursuant to subdivision (c) of Section 10234.95.

(6) The ''Notice to Applicant Regarding Replacement of Accident and Sickness or Long-Term Care Insurance'' pursuant to Section 10235.16 if replacement is not made by direct response solicitation or Section 10235.18 if replacement is made by direct response solicitation. Unless the solicitation was made by a direct response method, the agent and applicant shall both sign at the bottom of the checklist to indicate the required documents were delivered and received.

(d) If an insurer does not complete medical underwriting and resolve all reasonable questions arising from information submitted on or with an application before issuing the policy or certificate, then the insurer may only rescind the policy or certificate or deny an otherwise valid claim, upon clear and convincing

evidence of fraud or material misrepresentation of the risk by the applicant. The evidence shall:

(1) Pertain to the condition for which benefits are sought.

(2) Involve a chronic condition or involve dates of treatment before the date of application.

(3) Be material to the acceptance for coverage.

(e) No long-term care policy or certificate may be field issued.

(f) The contestability period as defined in Section 10350.2 for long-term care insurance shall be two years.

(g) A copy of the completed application shall be delivered to the insured at the time of delivery of the policy or certificate.

(h) Every insurer shall maintain a record, in accordance with Section 10508, of all policy or certificate rescissions, both state and countrywide, except those voluntarily initiated by the insured, and shall annually furnish this information to the commissioner in a format prescribed by the commissioner.

SEC. 4. Section 10232.4 of the Insurance Code is amended to read:

10232.4. (a) No long-term care insurance policy or certificate other than a group policy or certificate, as described in subdivision (a) of Section 10231.6, shall use a definition of preexisting condition which is more restrictive than a condition for which medical advice or treatment was recommended by, or received from a provider of health care services, within six months preceding the effective date of coverage of an insured person.

(b) Every long-term care insurance policy or certificate shall cover preexisting conditions that are disclosed on the application no later than six months following the effective date of the coverage of an insured, regardless of the date the loss or confinement begins.

(c) The definition of preexisting condition does not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant, and on the basis of the answers on that

application, from underwriting in accordance with that insurer's established underwriting standards. Unless otherwise provided in the policy or certificate a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in subdivision (b) expires. Unless a waiver or rider has been specifically approved by the commissioner, no long-term care insurance policy or certificate may exclude or use waivers or riders of any kind to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions beyond the waiting period described in subdivision (b).

SEC. 5. Section 10232.92 of the Insurance Code is repealed.

SEC. 6. Section 10232.92 is added to the Insurance Code, to read:

10232.92. Every long-term care policy or certificate covering confinement in a nursing facility shall also include a provision with the following features:

(a) Care in a residential care facility must be covered. ''Residential care facility'' means a facility licensed as a residential care facility for the elderly or a residential care facility as defined in the Health and Safety Code. Outside California, eligible providers are facilities that meet applicable licensure standards, if any, and are engaged primarily in providing ongoing care and related services sufficient to support needs resulting from impairment in activities of daily living or impairment in cognitive ability and which also provide care and services on a 24-hour basis, have a trained and ready-to-respond employee on duty in the facility at all times to provide care and services, provide three meals a day and accommodate special dietary needs, have agreements to ensure that residents receive the medical care services of a physician or nurse in case of emergency, and, have appropriate methods and procedures to provide necessary assistance to residents in the management of prescribed medications.

(b) The benefit amount payable for care in a residential care facility shall be no less than 70 percent of the benefit amount payable for institutional confinement.

(c) All expenses incurred by the insured while confined in a residential care facility, for long-term care services that are necessary diagnostic, preventative, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance or personal care services, needed to assist the insured with the disabling conditions that cause the insured to be a chronically ill individual as authorized by Public Law 104-191 and regulations adopted pursuant thereto, shall be covered and payable, up to but not to exceed the maximum daily residential care facility benefit of the policy or certificate. There shall be no restriction on who may provide the service or the requirement that services be provided by the residential care facility, as long as the expenses are incurred while the insured is confined in a residential care facility, the reimbursement does not exceed the maximum daily residential care facility benefit of the policy or certificate, and the services do not conflict with federal law or regulation for purposes of qualifying for favorable tax consideration provided by Public Law 104-191.

(d) In policies or certificates that are not intended to be federally qualified, the threshold establishing eligibility for care in a residential care facility shall be no more restrictive than that for home care benefits, as defined in subdivision (a) of Section 10232.8, and the definitions of impairment in activities of daily living and impairment of cognitive ability shall be the same as for home care benefits, as defined in subdivisions (a) and (g) of Section 10232.8. In policies or certificates that are intended to be federally qualified, the threshold establishing eligibility for care in a residential care facility shall be no more restrictive than that for home care benefits, as defined in subdivision (b) of Section 10232.8, and the definitions of impairment in activities of daily living and impairment in cognitive ability shall be the

same as those for home care benefits as defined in subdivisions (b), (c), (d), (e), and (f) of Section 10232.8.

SEC. 7. Section 10232.97 is added to the Insurance Code, to read:

10232.97. In every long-term care policy or certificate that covers care in a nursing facility, the threshold establishing eligibility for nursing facility care shall be no more restrictive than a provision that the insured will qualify if either one of two criteria are met:

(a) Impairment in two activities of daily living.

(b) Impairment in cognitive ability.

SEC. 8. Section 10233.2 of the Insurance Code is amended to read:

10233.2. Long-term care insurance may not:

(a) Be canceled, nonrenewed, or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of the insured individual or certificate holder.

(b) Contain a provision establishing a new waiting period in the event existing coverage is converted to, or replaced by, a new or other form within the same insurer, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder.

(c) Provide coverage for skilled nursing care only or provide significantly more coverage for skilled care in a facility than coverage for lower levels of care.

(d) Provide for payment of benefits based on a standard described as ‘‘usual and customary,’’ ‘‘reasonable and customary,’’ or words of similar import.

(e) Terminate a policy, certificate, or rider, or contain a provision that allows the premium for an in-force policy, certificate, or rider, to be increased due to the divorce of a policyholder or certificate holder.

(f) Include an additional benefit for a service with a known market value other than the statutorily required home- and community-based service benefits in Section 10232.9, the assisted living benefit in Section 10232.92, or a nursing facility benefit, unless the additional benefit provides for the payment of at least five times the daily

benefit and the dollar value of the additional benefit is disclosed in the schedule page of the policy.

SEC. 9. Section 10233.5 of the Insurance Code is amended to read:

10233.5. (a) An outline of coverage shall be delivered to a prospective applicant for long-term care insurance at the time of initial solicitation through means which prominently direct the attention of the recipient to the document and its purpose.

(b) In the case of agent solicitations, an agent shall deliver the outline of coverage prior to the presentation of an application or enrollment form.

(c) In the case of direct response solicitations, the outline of coverage shall be presented in conjunction with any application or enrollment form.

(d) The outline of coverage shall be a freestanding document, using no smaller than 10-point type.

(e) The outline of coverage shall contain no material of an advertising nature.

(f) Use of the text and sequence of the text of the outline of coverage set forth in this section is mandatory, unless otherwise specifically indicated.

(g) Text which is capitalized or underscored in the outline of coverage may be emphasized by other means which provide prominence equivalent to capitalization or underscoring.

(h) The outline of coverage shall be in the following form:

‘‘(COMPANY NAME)

(ADDRESS—CITY AND STATE)

(TELEPHONE NUMBER)

LONG-TERM CARE INSURANCE

OUTLINE OF COVERAGE

(Policy Number or Group Master Policy and Certificate Number)

1. This policy is (an individual policy of insurance) ((a group policy) which was issued in the (indicate jurisdiction in which group policy was issued)).

2. PURPOSE OF OUTLINE OF COVERAGE. This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual or group policy contains governing contractual provisions. This means that the policy or group policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you READ YOUR POLICY (OR CERTIFICATE) CAREFULLY!

3. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED.

(a) Provide a brief description of the right to return—‘‘free look’’ provision of the policy.

(b) Include a statement that the policy either does or does not contain provisions providing for a refund or partial refund of premium upon the death of an insured or surrender of the policy or certificate. If the policy contains those provisions, include a description of them.

4. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the insurance company.

(a) (For agents) Neither (insert company name) nor its agents represent Medicare, the federal government or any state government.

(b) (For direct response) (insert company name) is not representing Medicare, the federal government or any state government.

5. LONG-TERM CARE COVERAGE. Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community, or in the home.

This policy provides coverage in the form of a fixed dollar indemnity benefit for covered long-term care expenses, subject to policy (limitations) (waiting periods) and (coinsurance) requirements. (Modify this paragraph if the policy is not an indemnity policy.)

6. BENEFITS PROVIDED BY THIS POLICY.

(a) (Covered services, related deductible(s), waiting periods, elimination periods, and benefit maximums.)

(b) (Institutional benefits, by skill level.)

(c) (Noninstitutional benefits, by skill level.)

(Any benefit screens must be explained in this section. If these screens differ for different benefits, explanation of the screen should accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too must be specified. If activities of daily living (ADLs) are used to measure an insured's need for long-term care, then these qualifying criteria or screens must be explained.)

7. LIMITATIONS AND EXCLUSIONS.

(Describe:

(a) Preexisting conditions.

(b) Noneligible facilities/provider.

(c) Noneligible levels of care (e.g., unlicensed providers, care or treatments provided by a family member, etc.).

(d) Exclusions/exceptions.

(e) Limitations.)

(This section should provide a brief specific description of any policy provisions which limit, exclude, restrict, reduce, delay, or in any other manner operate to qualify payment of the benefits described in (6) above.)

THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG-TERM CARE NEEDS.

8. RELATIONSHIP OF COST OF CARE AND BENEFITS. Because the costs of long-term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. (As applicable, indicate the following:

(a) That the benefit level will NOT increase over time.

(b) Any automatic benefit adjustment provisions.

(c) Whether the insured will be guaranteed the option to buy additional benefits and the basis upon which benefits will be increased over time if not by a specified amount or percentage.

(d) If there is a guarantee, include whether additional underwriting or health screening will be required, the frequency and amounts of the upgrade options, and any significant restrictions or limitations.

(e) And finally, describe whether there will be any additional premium charge imposed, and how that is to be calculated.)

9. TERMS UNDER WHICH THE POLICY (OR CERTIFICATE) MAY BE CONTINUED IN FORCE OR DISCONTINUED.

(a) Describe the policy renewability provisions.

(b) For group coverage, specifically describe continuation/conversion provisions applicable to the certificate and group policy.

(c) Describe waiver of premium provisions or state that there are no waiver of premium provisions.

(d) State whether or not the company has a right to change premium, and if that right exists, describe clearly and concisely each circumstance under which the premium may change.

10. ALZHEIMER'S DISEASE, ORGANIC DISORDERS, AND RELATED MENTAL DISEASES.

(State that the policy provides coverage for insureds clinically diagnosed as having Alzheimer's Disease, organic disorders, or related degenerative and dementing illnesses. Specifically describe each benefit screen or other policy provision that provides preconditions to the availability of policy benefits for that insured.)

11. PREMIUM.

(a) State the total annual premium for the policy.

(b) If the premium varies with an applicant's choice among benefit options, indicate the portion of annual premium which corresponds to each benefit option.

12. ADDITIONAL FEATURES.

(a) Indicate if medical underwriting is used.

(b) Describe other important features.

13. INFORMATION AND COUNSELING. The California Department of Insurance has prepared a Consumer Guide to Long-Term Care Insurance. This guide can be obtained by calling the Department of Insurance toll-free telephone number. This number is 1-800-927-HELP. Additionally, the Health Insurance Counseling and Advocacy Program (HICAP) administered by the California Department of Aging, provides long-term care insurance counseling to California senior citizens. Call the HICAP toll-free telephone number 1-800-434-0222 for a referral to your local HICAP office.''

SEC. 9.5. Section 10235.2 of the Insurance Code is amended to read:

10235.2. No long-term care insurance policy delivered or issued for delivery in this state shall use the terms set forth below, unless the terms are defined in the policy and the definitions satisfy the following requirements:

(a) ‘‘Medicare’’ shall be defined as the ‘‘Health Insurance for the Aged Act,’’ Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended, or Title I, Part I of Public Law 89-97, as enacted by the 89th Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof, or words of similar import.

(b) ‘‘Skilled nursing care,’’ ‘‘intermediate care,’’ ‘‘home health care,’’ and other services shall be defined in relation to the level of skill required, the nature of the care and the setting in which care is required to be delivered.

(c) All providers of services, including, but not limited to, skilled nursing facilities, intermediate care facilities, and home health agencies shall be defined in relation to the services and facilities required to be available and the licensure or degree status of those providing or supervising the services. The definition may require that the provider be appropriately licensed or certified.

SEC. 10. Section 10235.8 of the Insurance Code is amended to read:

10235.8. No policy may be delivered or issued for delivery in this state as long-term care insurance if the policy limits or excludes coverage by type of illness, treatment, medical condition, or accident, except as to the following:

(a) Preexisting conditions or diseases.

(b) Alcoholism and drug addiction.

(c) Illness, treatment, or a medical condition arising out of any of the following:

(1) War or act of war, whether declared or undeclared.

(2) Participation in a felony, riot, or insurrection.

(3) Service in the armed forces or units auxiliary thereto.

(4) Suicide, whether sane or insane, attempted suicide, or intentionally self-inflicted injury.

(5) Aviation in the capacity of a non-fare-paying passenger.

(d) Treatment provided in a government facility, unless otherwise required by law, services for which benefits are available under Medicare or other governmental programs (except Medi-Cal or medicaid), any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no fault law, services provided by a member of the covered person's immediate family, and services for which no charge is normally made in the absence of insurance.

This section does not prohibit exclusions and limitations by type of provider or territorial limitations.

SEC. 11. Section 10235.30 of the Insurance Code is amended to read:

10235.30. (a) No insurer may deliver or issue for delivery a long-term care policy in this state unless the insurer offers at the time of application an option to purchase a shortened benefit period nonforfeiture benefit with the following features:

(1) Eligibility begins no later than after 10 years of premium payments.

(2) The lifetime maximum benefit is no less than the dollar equivalent of three months of care at the nursing facility per diem benefit contained in the policy or the amount of the premiums paid, whichever is greater.

(3) The same benefits covered in the policy and any riders at the time eligibility begins are payable for a qualifying claim.

(4) The lifetime maximum benefit may be reduced by the amount of any claims already paid.

(5) Cash back, extended term, and reduced paid-up forms of nonforfeiture benefits shall not be allowed.

(6) The lifetime maximum benefit amount increases proportionally with the number of years of premium payment.

(b) This section shall not apply to life insurance policies that accelerate benefits for long-term care.

SEC. 12. Section 10235.40 of the Insurance Code is amended to read:

10235.40. (a) No individual long-term care policy or certificate shall be issued until the applicant has been given the right to designate at least one individual, in addition to the applicant, to receive notice of lapse or termination of a policy or certificate for nonpayment of premium. The insurer shall receive from each applicant one of the following:

(1) A written designation listing the name, address, and telephone number of at least one individual, in addition to the applicant, who is to receive notice of lapse or termination of the policy or certificate for nonpayment of premium.

(2) A waiver signed and dated by the applicant electing not to designate additional persons to receive notice. The required waiver shall read as follows:

‘‘Protection Against Unintended Lapse.

I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid. I elect not to designate any person to receive the notice.

_____ _____

Signature of Applicant Date’’

(b) The insurer shall notify the insured of the right to change the written designation, no less often than once every two years.

(c) When the policyholder or certificate holder pays the premium for a long-term care insurance policy or certificate through a payroll or pension deduction plan, the requirements contained in subdivision (a) need not be met until 60 days after the policyholder or certificate holder is no longer on that deduction payment plan. The application or enrollment form for a certified long-term

care insurance policy or certificate shall clearly indicate the deduction payment plan selected by the applicant.

(d) No individual long-term care policy or certificate shall lapse or be terminated for nonpayment of premium unless the insurer, at least 30 days prior to the effective date of the lapse or termination, gives notice to the insured and to the individual or individuals designated pursuant to subdivision (a), at the address provided by the insured for purposes of receiving notice of lapse or termination. Notice shall be given by first-class United States mail, postage prepaid, not less than 30 days after a premium is due and unpaid.

(e) Each long-term care insurance policy or certificate shall include a provision which, in the event of lapse, provides for reinstatement of coverage, if the insurer is provided with proof of the insured's cognitive impairment or the loss of functional capacity. This option shall be available to the insured if requested within five months after termination and shall allow for the collection of a past due premium, where appropriate. The standard of proof of cognitive impairment or loss of functional capacity shall not be more stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity contained in the policy certificate.

SEC. 13. Section 10235.50 of the Insurance Code is amended to read:

10235.50. Every policy or certificate shall include a provision that gives the policyholder or certificate holder the following rights to reduce coverage and lower premiums:

(a) A right, exercisable any time after the first year, to retain a policy or certificate while lowering the premium in no fewer than the following three ways:

(1) Reducing the lifetime maximum benefit.

(2) Reducing the nursing facility per diem and reducing the home- and community-based service benefits of a home care only policy and of a comprehensive long-term care policy.

(3) Converting a ‘‘comprehensive long-term care’’ policy or certificate to a ‘‘Nursing Facility Only’’ or a ‘‘Home Care Only’’ policy or certificate, if the insurer issues those policies or certificates for sale in the state.

(b) The premium for the policy or certificate that is reduced in coverage will be based on the age of the insured at issue age and the premium rate applicable to the amount of reduced coverage at the original issue date.

(c) If the contract in force at the time a reduction in coverage is made provides for benefit adjustments for anticipated increases in the costs of long-term care services, then the reduced nursing facility per diem, lifetime maximum benefit, and daily, weekly, or monthly home care benefits shall be adjusted in the same manner and in the same amount as the contract in force prior to the reduction in coverage.

(d) In the event a policy or certificate is about to lapse, the insurer shall provide written notice to the insured of the options in subdivision (a) to lower the premium by reducing coverage and of the premiums applicable to the reduced coverage options. The insurer may include in the notice additional options to those required in subdivision (a). The notice shall provide the insured at least 30 days in which to elect to reduce coverage and the policy shall be reinstated without underwriting if the insured elects the reduced coverage.

(e) In the event of a premium increase, the insured shall be offered the option to lower premiums and reduce coverage.

SEC. 14. Section 10235.52 of the Insurance Code is amended to read:

10235.52. (a) Every policy shall contain a provision that, in the event the insurer develops new benefits or benefit eligibility or new policies with new benefits or benefit eligibility not included in the previously issued policy, the insurer will grant current holders of its policies who are not in benefit or within the elimination period the following rights:

(1) The policyholder will be notified of the availability of the new benefits or benefit eligibility or new policy

within 12 months. The insurer's notice shall be filed with the department at the same time as the new policy or rider.

(2) The insurer shall offer the policyholder new benefits or benefit eligibility in one of the following ways:

(A) By adding a rider to the existing policy and paying a separate premium for the new benefit or benefit eligibility based on the insured's attained age. The premium for the existing policy will remain unchanged based on the insured's age at issuance.

(B) By replacing the existing policy or certificate in accordance with Section 10234.87.

(C) By replacing the existing policy or certificate with a new policy or certificate in which case consideration for past insured status shall be recognized by setting the premium for the replacement policy or certificate at the issue age of the policy or certificate being replaced.

(b) The insured may be required to undergo new underwriting, but the underwriting can be no more restrictive than if the policyholder or certificate holder were applying for a new policy or certificate.

(c) The insurer of a group policy as defined under subdivisions (a) to (c), inclusive, of Section 10231.6 must offer the group policyholder the opportunity to have the new benefits and provisions extended to existing certificate holders, but the insurer is relieved of the obligations imposed by this section if the holder of the group policy declines the issuer's offer.

SEC. 15. Section 10235.94 is added to the Insurance Code, to read:

10235.94. Every policy or certificate shall include a provision giving the policyholder or certificate holder the right to appeal decisions regarding benefit eligibility, care plans, services and providers, and reimbursement payments.

SEC. 16. Section 10237.1 of the Insurance Code is amended to read:

10237.1. No insurer may deliver or issue for delivery a long-term care insurance policy or certificate in this state unless the insurer offers to each policyholder and

certificate holder, in addition to any other inflation protection, the option to purchase a long-term care insurance policy or certificate that provides for benefit levels and benefit maximums to increase to account for reasonably anticipated increases in the costs of long-term care services covered by the policy. Insurers shall offer to each policyholder and certificate holder, at the time of purchase, the option to purchase a long-term care insurance policy or certificate containing an inflation protection feature which is no less favorable than one that does one or more of the following:

(a) Increases benefit levels annually in a manner so that the increases are compounded annually at a rate of not less than 5 percent.

(b) Guarantees the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status and without regard to claim status or history so long as the option for the previous period has not been declined. The amount of the additional benefit shall be no less than the difference between the existing policy benefit and that benefit compounded annually at a rate of at least 5 percent for the period beginning with the purchase of the existing benefit and extending until the year in which the offer is made.

(c) Covers a specified percentage of actual or reasonable charges and does not include a maximum specified indemnity amount limit.

(d) The insurer of a group long-term care insurance policy as defined in subdivision (a), (b), or (c) of Section 10231.6, shall offer the holder of the group policy the opportunity to have the inflation protection pursuant to this section extended to existing certificate holders, but the insurer is relieved of the obligations imposed by this section if the holder of the group policy declines the insurer’s offer.

SEC. 17. Section 10237.4 of the Insurance Code is amended to read:

10237.4. (a) Inflation protection benefit increases under a policy that contains these benefits shall continue

without regard to an insured's age, claim status or claim history, or the length of time the person has been insured under the policy.

(b) An offer of inflation protection that provides for automatic benefit increases shall include an offer of a premium which the insurer expects to remain constant. The offer shall disclose in a conspicuous manner that the premium may change in the future unless the premium is guaranteed to remain constant.

(c) The inflation protection benefit increases under a policy or certificate that contains an inflation protection feature shall not be reduced due to the payment of claims.

SEC. 18. Section 10237.5 of the Insurance Code is amended to read:

10237.5. (a) An inflation protection provision that increases benefit levels annually in a manner so that the increases are compounded annually at a rate not less than 5 percent shall be included in a long-term care insurance policy unless an insurer obtains a rejection of inflation protection signed by the policyholder.

(b) The rejection, to be included in the application or on a separate form, shall state:

''I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protection. Specifically, I have reviewed the plan, and I reject 5 percent annual compound inflation protection.

_____ _____

Signature of Applicant Date''

Approved _____, 1999

_____

Governor